September 8, 2010

Commission's Secretary
Federal Communications Commission
445 12th Street SW
Room TW-A325
Washington, D.C. 20554

Re: **Comments-Notice of Proposed Rulemaking Rural Health Care Support Mechanism**
FCC 10-125 WC Docket No. 02-60

To the Commissioners:

The Washington Rural Health Association (WRHA) represents rural constituents throughout Washington State, and working to improve health and health care in the state. We do this in conjunction with our organizational partners including the Washington State Department of Health and the Statewide Office of Rural Health. Our partnerships have a rich history of creating programs and providing resources that help meet the healthcare needs of their rural citizens. These efforts include providing technical assistance and other support that rural communities and healthcare providers need to implement and utilize HIT initiatives.

In forming its comments, WRHA considered the needs of a wide range of health providers including safety net providers of all types, critical access hospitals, skilled nursing facilities and emergency medical providers. In addition to soliciting comments from 50 SORH, WRHA has consulted with small telco organizations, small rural health care providers and other national associations to formulate our comments. WRHA supports the National Association of EMS Officials comments and encourages the FCC to further continue its efforts to address the technological issues of health care providers as they meet the needs of some of the most underserved Americans in the country.

The comments offered do not speak to all elements in the NPRM, but do reflect issues of importance to rural health care providers as recognized by Washington's State Office of Rural Health and the WRHA. Comments respond to specific requests by the FCC for comment and are organized by the section number of the NPRM **FCC 10-125 WC Docket No. 02-60.**

Sincerely,

Nancy Nash Méndez

Nancy Nash-Méndez
President

SECTION III. HEALTH INFRASTRUCTURE PROGRAM

The FCC proposes to create a separate Health Infrastructure Program to subsidize up to 85 percent of construction costs of new regional or statewide networks that builds upon the Rural Health Care Pilot Program (RHCPP). WRHA supports the FCC's intent on expanding broadband infrastructure to support health information exchange and innovative models of health care delivery that depend upon robust telecommunications and provides comments on each of the proposed process steps.

15. Initial application phase comment.

Clarify urban HCP eligibility for infrastructure program. The NPRM does not clearly state whether urban non-profit and public HCPs are eligible to participate in the infrastructure program as part of a dedicated health care network. The Rural Health Care Pilot Program recognized the importance of including urban providers in a network, providing that a majority of HCPs in the network were rural. Much of remotely-delivered health care is dependent upon rural HCP access to urban providers for receipt of telehealth services and health information. This deserves clarification, and inclusion of urban providers in a dedicated health care network is essential for access to services otherwise unavailable.

16. Project selection phase - comment on limiting the total number of projects that may be selected in given year and on prioritization rules to be applied by USAC in the event that funding requests exceed the annual amount available under the health infrastructure program.

The Commission should develop objective application scoring criteria for predicting successful, sustainable network projects. The FCC noted in its comments that some of the Pilot projects were ill prepared and that a smaller amount of projects would allow USAC to devote greater resources to ensure success. We concur. The Pilot project did not go far enough in evaluating the projected success of each application prior to funding announcements. Instead, projects were subject to an open-ended examination of their sustainability, which caused significant delays and undue burden to existing projects. Predicted success and sustainability must be part of any thorough application review. Furthermore, program requirements should be spelled out in advance, not during the implementation process. Applications scoring criteria should include clear project goals, evidence of sustainability and demonstrated organizational, business, financial and technical capacity. Those failing to meet the scored criteria should receive feedback, if possible, and have an opportunity to reapply for funding in subsequent years. This early scrutiny will serve not only the FCC in ensuring the success of funded projects through targeted technical assistance, but will also assist those projects that do not meet the funding criteria to identify areas of improvement for future successful re-application.

17. Comment on Project commitment phase.

Comment: We support verification of the agreements to comply with program requirements specifically related to contribution requirements. The Commission itself notes that the Rural Health Care Pilot Program has learned that applicants have difficulty in meeting a 15 percent requirement. The health care infrastructure program proposes to serve a disadvantaged group of health care providers to provide safe, accessible health care. We support a fifteen percent direct HCP contribution which will allow for in-kind contributions related to the infrastructure development. This is attainable for most rural HCPs and yet requires participants to have a financial stake in the success of the network.

20. Should the Commission set a minimum threshold for broadband connectivity speeds under the health infrastructure program?

The proposed minimum broadband speed of 10 Mbps requirement for infrastructure projects may be unattainable for some rural health care providers; a more flexible approach is encouraged. Modifying the FCC's current definition of broadband (768Kbps) is appropriate and aligns with recommendations in the National Broadband Plan. The plan, however, recognizes the varying requirements for types of health care providers,

citing 4Mbps as appropriate for a small physician office, and increasing according to size of facility and type of health care provided. Requiring 10 Mbps for any provider attempting to participate in a networked solution may exclude certain rural or small providers. Setting standards for the industry while maintaining flexibility in accordance with the type of provider may be necessary to ensure broad participation and access. We support minimum standards for Quality of Service and latency as a component of any competitive bid. A required standard for latency of 10 milliseconds should be an expectation.

47. Eligible Sources

The commission proposes placing limitations on the eligible sources for matching funds, with limitations to eligible health care providers in particular who do not demonstrate that 15 percent contribution is derived from a cash source.

In rural and frontier areas of the state in which the Commission supports grants to expand broadband infrastructure, consideration should be given to recurring charges that will be imposed by the telecommunications industry on the health care providers. Some rural health recipients of the current pilot program were unable to implement their approved program when they learned that they were unable to afford either the 15 percent cash match, or the recurrent charges that would be imposed by the telecommunications company for ongoing services.

The 15 percent cash match policy should be modified to allow for a mix of cash and in-kind match for recipients of the expanded pilot program.

SECTION IV. BROADBAND SERVICES PROGRAM

93. Fifty percent subsidy proposal

A flat 50 percent subsidy would significantly disadvantage remotely rural health care providers that need it most. The NPRM is unclear as to whether the health broadband services program will replace both of the current telecommunications and internet access programs or only the internet program.

We recognize that many eligible rural health providers do not currently apply for the current rural health telecommunications discount, and believe in many cases; the reason is that they believe the staff effort required for the initial application is not worth the financial gain.

The 50 percent subsidy should be increased to at least 65 percent, thus providing a more realistic incentive for applications. The demand increase will inevitably result in the aggregate annual cap of $400m for the Rural Health Care Support Mechanism being reached quickly, leaving in its wake administrative challenges for prioritizing funding in the event that qualifying projects collectively exceed the legislative cap.

97. Minimum level of broadband capability.

A minimum 4Mbps broadband speed should not prevent rural HCPs from participating in the program. In keeping with the recommendation of the National Broadband Plan and supporting a goal of overall broadband development to support health care, 4Mbps is an appropriate minimum standard. However, there are concerns about whether small rural HCPs would be unable to access the recommended minimum due to unavailability and would therefore become ineligible for subsidy. There are still HCPs in rural areas that struggle to get a 1.5Mpbs connection due to limitations of local service providers and disinterest on the part of larger providers. Rural HCPs with limited broadband access should not be required to bear the cost of service provider upgrades in order to participate in the broadband services program.

SECTION V. ELIGIBLE HEALTH CARE PROVIDERS

115.

As hospitals, medical specialists, and other sources of specialty and general medical care decline in number in rural areas, EMS providers are increasingly called upon to help address those gaps, becoming integral in more areas than just emergency response in the delivery of care. They have to transport an increasing number of patients to medical centers ever further away and to provide a higher level of care during those extended episodes of care and transport.

WRHA is pleased that the FCC has included "ambulance services" in Paragraph 8 of its Initial Regulatory Flexibility Analysis ("IRFA"), included in this NPRM. We assume that this reflects an intention on the Commission's part to include EMS in its enablement of rural health care broadband development. However, that the Commission makes no specific reference in the body of the NPRM itself to EMS agencies (ambulance and non-transporting emergency medical services, and EMS agencies providing community paramedicine or other similar primary care services) as eligible health care providers for the purposes of this proceeding and rules. This leaves to interpretation whether or not such EMS agencies are included as "local health agencies" and qualify for the benefits provided.

Emergency medical services may be operated by a variety of entities and under one of many business arrangements. For example, an ambulance service (or non-transporting first responder service, or community paramedicine service) may be a part of a hospital or clinic, a fire department or police agency, or may be an independent volunteer or commercial agency. It may operate under a non-profit, public utility, governmental or for-profit business model. These considerations have led, anecdotally, to interpretations that EMS agencies should not benefit from Federal government provisions afforded others. Regardless of any of these considerations, EMS agencies serve local citizens and governments in an ever-broadening role as 9-1-1 responders/long distance patient care and transport providers/primary care providers in rural health settings, and should be interpreted by the FCC as a *local health agency* to qualify for the broadband benefits of these provisions.

Home Health Agencies that show evidence of patient use of electronic patient health records (PHR) should be considered eligible for the Rural Health Care Support Mechanism. Insufficient broadband capacity in many rural and frontier areas of the country prevent implementation of tele-home health care services that can save lives as well as money by reducing extensive travel time on the part of agency care-givers. While the proposed FCC initiative will expand broadband into remote areas of the country, it may not generate sufficient demand so as to create a critical mass of users to make the system build-out and related investment cost-effective. To that end, we believe that adding non-profit home health agencies that can show evidence of exchanging electronic patient health records with their patients should be considered eligible.

116. Eligibility for Off-Site administrative offices.

Off-site administrative offices should be allowed to participate in the Rural Health Care Support Mechanism, so long as legal proof is provided showing ownership or controllership by the eligible rural health providers. We agree that a 51 percent rule governing ownership should be applied.

SECTION VI. ANNUAL CAPS AND PRIORITIZATION RULES

128. **Aggregate Annual Cap**

To ensure continued rural parity in discount distribution to rural health providers we recommend that funds set aside for the proposed broadband grant program be reduced from $100 million (out of the $400 million) for infrastructure projects under the health infrastructure program to $50 million.

134. **Competitive process**

We do not recommend that the Commission set aside funding for a competitive process that demonstrates innovative uses of broadband connectivity to meet health care needs in a community. Our reason for this

recommendation is simple. Rural health care providers often do not have staff capacity to write competitive grants, or funds to hire expensive grant writers who will write successful proposals in their behalf. Rural Health Support Mechanism funds should support an increased telecommunications discount for rural health providers.

130. Eligible health care providers based on their HPSA score.

Comment: WRHA supports a prioritization methodology for funding, but question the use of HPSAs in the prioritization; rather, a measure of rurality or remoteness of rural sites should be considered as a third-tier prioritization. We support the first two tiers of priorities: 1) total number of rural HCPs in proposed network; 2) total number of HCPs (both urban and rural). However, use of a HPSA score for urban providers is not an appropriate tool. Urban providers in a rural-urban network are likely to be medical centers or specialty clinics delivering care to remote sites; HPSA scores for these type of providers would not address need as much as consideration of remoteness or low density often experienced by rural health care providers in frontier regions.

SECTION IX. DATA GATHERING AND PERFORMANCE MEASURES

143. Should the Commission align its performance measures with HHS's meaningful use criteria?

Comment: We agree with the Commission's proposition that the adoption of performance measures will enhance the Commission's capacity to evaluate the extent to which expanded Broadband access will improve health care. However, we recommend that the Commission **NOT** require health care providers to provide such measures directly to the Commission or to USAC.

Current studies show that rural health care providers have fallen behind their urban counterparts for current reporting of measures into the Hospital Compare program, largely due to lack of funds and trained personnel to track and report data. The studies further reveal that the number of clinical cases documented by many small rural hospitals is too low to show any meaningful use progress. These issues should be resolved by HHS prior to the Commission's adoption of a meaningful use reporting requirement to the Commission or USAC.

When and if the Commission adopts meaningful use requirements, the Commission should enter into a data sharing agreement with federal agencies such as the Department of Health and Human Services, Department of Commerce, and Department of Agriculture. Such an agreement will prevent double reporting, and be more cost effective for rural health care providers that are already reporting performance measures to federal agencies. This alignment will enable the Commission to access meaningful use data already reported and recorded by federal agencies.

145. Performance criteria.

Comment: We recommend adoption of the American Telemedicine Association's Standards and Guidelines for Tele dermatology, Tele mental Health and Tele pathology as an acceptable methodology for evaluating the effectiveness of Broadband utilization for medical services.

The Commission should also consider how advances in rural/rural, rural/urban health information exchange can be addressed as performance criteria.

146. Should the Commission require each program beneficiary to identify more specific performance measures?

Comment: Rural beneficiaries in particular will be able to offer different and creative ways of identifying their own performance measures. The measures they provide will offer useful information for innovative evaluation purposes, and the development of successful models for future replication and funding.

148. Examining the extent to which training will led to better broadband utilization and improved care.

Comment: Many rural health care providers currently provide telehealth services using existing telecommunications infrastructures. Some of the rural health care providers have immediate access to

sophisticated telehealth technology that their providers do not use. Many rural health providers currently do not apply for or receive USAC discounts for which they are eligible. The Commission should make funding available for training that will not only enable better broadband utilization, but show progress in using telemedicine systems that are in place as a result of the expanded broadband mechanisms.

149. Should the Commission allocate a portion of the rural health care funding for running trials of and evaluating innovative concepts, and if so, what amount should be set aside for that purpose?

Comment: We agree that evaluating innovative concepts is a worthwhile idea, and that funding should be set aside for this purpose, not on a permanent basis, but over a five-year trial period. The Rural Health Research Centers, funded by the Office of Rural Health Policy, HHS/HRSA, should be given priority as evaluators, as they bring extensive rural health experience and knowledge of the concepts addressed by the Commission in this ruling.

SECTION X. PROCEDURAL MATTERS

We recommend that the Rural Health Support Mechanism administrative program (the Universal Services Administrative Corporation or its equivalent) be required by the Commission to include on its board representation from a national rural health organization such as the National Organization of State Offices of Rural Health in order to more effectively generate collaborative efforts with rural constituencies.